6 Year Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Weight: | Percentile: | Height: | Percentile: | BMI: | Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam	**Temp:**
OD	**Pulse:**
OS	**Resp:**
OU	**BP**
Corrected / uncorrected	**BP elevated?**

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? (Audiometry): Yes ___ No ___ **Speech:** Within normal limits? Yes ___ No ___

Developmental Screen: Age Appropriate? (e.g., school attendance, reading at grade level) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (Pediatric Symptom Checklist, parental interview, observation) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	**Yes**	**No**	**Describe abnormal findings:**
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____

(perform if at risk)

SCREENINGS

Verbal Lead Risk Assessment _____

Blood Lead Test _____

(perform at 36-72 mo of age)

ADDITIONAL LABS ORDERED:

Hgb/Hct Yes ___ No ___

Urinalysis Yes ___ No ___

Other:

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Given today?** ___ **Delayed?** ___ **Deferred?** ___

Hep B ___ **DTaP** ___ **IPV** ___ **MMR** ___ **Varicella** ___ **Hep A** ___ **Influenza** ___ **Other** ___

ANTICIPATORY GUIDANCE

- Drowning/sun safety
- Seat belts/air bags
- Sport/bike helmet use
- Sports/injury prevention
- Street safety
- Nutrition/exercise
- Dental care/sealants
- Age appropriate behavior
- Social interactions
- "Safe at Home?"
- Family involvement
- Next appointment

REFERRALS:

Behavioral _____ **Dental** _____ **Nutritional** _____ **Speech** _____ **DDD** _____ **ALTCS** _____ **CRS** _____

Specialty _____ **Developmental** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

Revised January 1, 2004